IHPA – Development of the Australian Emergency Care Classification – Public Consultation
C/- Health Policy Analysis
Suite 101, 30 Atchison Street
St Leonards, NSW
Via email: submissions.ihpa@ihpa.gov.au

WHA & CHA comments on the IHPA – Development of the Australian Emergency Care Classification – Public Consultation

Children's Healthcare Australasia (CHA) and Women's Healthcare Australasia (WHA) are peak Not-for-profit organisations supporting a network of 150 member hospitals & health services around Australia. We fully support the Development of the Australian Emergency Care Classification system, and believe that this work will result in a stronger and more capable health system in the future. In particular we feel that the ability to ascertain the care trajectory of numerous clinically relevant groups of conditions will improve hospital and jurisdictional decision-making and thus emergency department care in the future.

Introduction:

We understand the proposed Emergency Department classification system to have two scheduled timeframes for impact, those being a simplified three level version of classification that relies on data that is already collected and available within each jurisdiction. We then understand that subsequent to that a future version of the classification will be produced using the variables collected in the Emergency care costing study.

WHA & CHA have followed along with the process of IHPA undertaking the Emergency care costing study and feel that a strong and rigorous process has been undertaken, and that many aspects of emergency care have been dealt with by undertaking this process. We understand that emergency department diagnosis is the single most predictive measure of emergency department cost, and that the episode end status is next best followed by triage category and investigations which each have a similar level of predictive capability.

We understand the new 3 level classification structure (for speedy implementation) be firstly filtered by visit type, episode end status and then triage category. We understand that level 2 would comprise 66 clinically meaningful emergency department diagnosis clusters, to be known as Emergency Care Diagnosis Groups (ECDGs). The third level of classification introduces complexity splits.

Responses to consultation questions:

1. Are there any categories for level 1 that can be grouped together while remaining clinically meaningful?

It seems that visit type is a poor marker of cost. See Table 2 – Predictive performance of individual variables[i]. Perhaps DNW and Left at own risk can move into Emergency Presentation but then break away into the "end classes" or into "complexity" increasing that Level into 6 classes.

DNW and Left at own risk patients in paediatric emergency medicine are a significant source of work, and concern, although we are aware that some data on the DNW cohort has been published suggesting that these children come to little harm as the result of failing to wait. Member services suggest that the paediatric cohort of Left at own risk has a number of inherent (resource and potential cost related) issues. There are Child Protection considerations that may involve the use of additional resources (e.g. child safety risk assessment, gaining speedy access to Social Work services, Child Protection staff involvement/reporting, etc.).

In level 1 our members noted that "Return visit, planned" could be removed from a cost perspective, and could be integrated into the more general "emergency presentation" category.

Tertiary services suggest that the Source of referral for tertiary emergency department services should also be considered. There is a strong argument that patients referred to tertiary services are inherently more resource intensive. Tertiary services also suggest that some of the single end class level 1 categories be split with consideration of the additional resources required in the paediatric setting.

We suggest that for "Dead on arrival" in the paediatric setting, there are greater resource requirements (senior medical staff, social workers, multiple nurses for family support, on call paediatricians required to complete unique paperwork such as SUDI documentation).

2. Are there any ECDGs that can be grouped together while remaining clinically meaningful?

Our members suggest the following:

- URTI could be collapsed into the "viral illness" AECC end class without a significant change in cost.
- "Croup" is an "Upper respiratory tract infection" yet it appears in its own AECC end class. Could these be refined further/amalgamated?
- "Minor injury" implies that a severity measure of injury is used in the AECC end class. Should the injury relate to the body part injured and the severity be included in Level 3 "complexity". It is not a diagnosis in itself.
- "Perinatal disorders" could refer to the mother and/or the infant, and perhaps could be merged with other more system based AECC end classes. i.e. a 2 day old with fever could be classified in the "fever of unknown origin" or "septicaemia" or a "perinatal disorder".
- It is also possible that Fever of Unknown Origin and Septicaemia could be combined into the one category. CHA has had contact with international organisations with experience in the auditing of Sepsis and also of sizable paediatric services within the Australian setting that have shown that the proportion of young people with septicaemia who are identified early is somewhere between 11% and 60%. It is likely/probable that there is considerable overlap between these two classes. Cost comparisons show that they are very closely aligned and this may be beneficial in terms of simplicity for a future AECC.
- We note that Psychosis and Mental and behavioural disorder A & B are quite closely aligned and suggest that these could be amalgamated into the one class.
- We also note that the cost profile of the A & B classes of Alcohol and/or drug related mental health disorders is also similar to Mental & Behavioural disorders. We suggest that the clinical relevance of keeping these two classes separate is greater than the efficiency achieved from amalgamating the two and thus suggest that they are left as two distinct categories.

- We ask where issues of gender dysphoria and suicidality would appear in the currently proposed listing or if there were any presentations identified within the costing study that included this class of patient? One suggestion would be to include them in the mental health conditions because of the high rates of mental health conditions and suicidality that is associated with gender dysphoria. Should the individual present with urinary tract issues we suggest that these are classified under L672 Kidney & urinary tract disorder. If the person presents with a disorder of the reproductive system there is no current classification available. Could we suggest that one class be created (reproductive system disorder) and that consideration be given to either amalgamating the two classes or creating a secondary split to either male, female or gender undefined.

3. Are the variables included in the draft AECC relevant to clinicians, health service managers and other stakeholders?

Yes. It might help if there was some information available to outline the resource changes required to implement this approach.

Some services thought that Triage Category 3 has more in common with Triage categories 1 & 2 and thus suggest that consideration should be given to whether it is more appropriate to consolidate these together leaving Category 4 & 5 as a discrete set.

4. Are the end classes included in the draft AECC relevant to clinicians, health service managers and other stakeholders?

Yes.

Some services suggest that the use of the term 'complexity' to describe the splits within ECDGs for end classes may be confusing to clinicians and is likely to be misunderstood as pertaining to the severity of the emergency presentation. Some end classes may be classed as complex but simply represent additional costs incurred in the ED for treatment of less severe presentations (i.e. more interventions taking place in ED so patients can be discharged).

5. Are the proposed data items for the future version(s) of the AECC feasible to collect and report nationally?

This would depend on many factors including agility of hospital IT systems (Vis a vis hospital finance to support the infrastructure and labour cost to co-ordinate the transition), workforce training requirements and the frequency of data submission.

Some services with EMR capability suggest that the collection of a well-defined list of diagnosis modifiers, interventions and procedures is feasible, with the caveat that this must be supported by the technology e.g. designated drop down menus in EMR, in the various jurisdictions.

Some services comment that some of this data is already collected, but may not always be collected, recorded inconsistently or difficult to extract.

We note that the proposed end classes include Abuse & Neglect and ask whether consideration of a future 'Child at risk' or 'Child in Out of Home Care' class be considered as greater resource intensity/usage is required for this group of individuals and can greatly extend the length of the emergency department visit. In particular our members noted that there is a small but significant group of families who present to the emergency department with children with significant behavioural and

other associated disturbance, with a need to surrender their children to the health sector when they are no longer able to cope. This activity represents a very small sector of the community, but is associated with significant activity aimed at finding solutions for the individuals involved. We also note that for classification purposes that families can also present to the ED with elderly relatives with similar issues.

6. What is the feasibility for emergency services to collect an aggregated list of diagnosis codes? If feasible, what level would be appropriate?

Again, this depends on many factors including hospital IT systems, workforce and the frequency of data submission. We note that many hospitals and health services across Australia have implemented Electronic Medical Records over the last 2 years and the capacity for unique data to be collected from these systems is significantly improved in this environment.

7. What other issues should be considered in the development of the AECC?

Our members agree completely with the move towards a diagnosis driven classification system for the ED setting. Triage category is not the primary determinant of resource utilisation and reliance on this approach is seriously flawed. Our members are heartened that IHA is working on the development of a classification system that is more aligned to resource intensity.

Age groupings - the proposed system groups ages 15-69 together. WHA & CHA members think that the needs of young people and adolescents could be lost in this categorisation. A significant example is the case of gender dysphoria for young people who are questioning about their gender. There is evidence that this can lead to higher levels of mental health conditions, suicidality and other associated conditions that would cause an ED presentation. Our members think the age brackets 15-24 and then 25-69 act as a better division, although we fully accept that such divisions are arbitrary. We specify 25 because many youth (not all) have completed at least part of their education (school and subsequent learning), joined the workforce or the ranks of the unemployed, and may be seen to be more individually responsible and independent.

Our members propose that analysis be undertaken using a wider sample of paediatric data. Members suggest that the data collected as part of the Emergency Care costing study and used to develop the AECC may not accurately reflect the following for paediatric facilities:

- Variation in acuity (for example number of trauma patients in sample)
- Variation in socioeconomic status, FACS involvement and Out of Home Care/Child at risk

The mean costs for paediatric age groups presented in the Emergency Care costing study does not appear to reflect some additional resources required in treatment of children in an Emergency department, such as:

- Higher staffing requirements as often more than one clinical staff member required to complete even simple interventions with children (e.g. assisting in holding a patient during insertion of a cannula)
- Greater time spent in emergency departments due to procedures / interventions taking longer or a preference for monitoring of patients over an extended period rather than performing diagnostic procedures immediately.
- Paediatric patients often require sedation or local anaesthetic in situations where adult patients do not.
- Clinical practice in emergency departments is governed by guidelines for certain types of emergency presentations (e.g. bronchiolitis or head injuries) – consideration in using these

guidelines to inform classification development may be useful in aligning the classification system and clinical practice.

In summary:

CHA & WHA strongly support the proposed amendments to the Australian Emergency Care Classification system; we look forward to working further with IHPA to refine this further as necessary.

Please contact our CEO Dr Barb Vernon on (02) 6175 1900 for any further assistance or to gain expert comment on any area in relation to this submission.

We would be very happy to assist the Independent Hospital Pricing Authority with this work at some stage in the future, and wish to make WHA & CHA available to discuss this at an appropriate time.

Yours sincerely,

Julie Hale
Deputy Chief Executive Officer

8 December 2017

[i] Health Policy Analysis – Independent Hospital Pricing Authority, Development of the Australian Emergency Care Classification, Public Consultation Paper, November 2017, p. 13.